

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **37246**
Registrar's No. **9519**

Registration District No. **791** Primary Registration District No. **1003**

1. PLACE OF DEATH:

(a) County.....

(b) City or town **St Louis**
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Phillips Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **20 days**
(Specify whether years, months or days)

In this community **9 years**
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County.....

(c) City or town **St Louis** **21**
(If outside city or town limits, write "RURAL")

(d) Street No. **1418 Franklin**
(If rural, give location)

(e) If foreign born, how long in U. S. A. ? years.

3. (a) PRINT FULL NAME **Ernest Williams**

8. (b) If veteran, name war..... 8. (c) Social Security No. **None**

4. Sex **male** 5. Color or race **col.** 6. (a) ~~Single, widowed, married, divorced~~ **married**

6. (b) Name of husband or wife **Bernice Williams** 6. (c) Age of husband or wife if alive **35** years

7. Birth date of deceased **June, 6, 1903**
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **November** day **16**
year **1940** hour **4:15** minute **A. M.**

21. I hereby certify that I attended the deceased from **October 26**, 1940, to **November 16**, 1940,
that I last saw him alive on **November 16**, 1940,
and that death occurred on the date and hour stated above.

8. AGE: **37** years **5** Months **10** Days If less than one day hr. min.

Immediate cause of death **Fecal Fistula, non malignant Ileo-Cecitis** **5 mos 10 mos ?**
~~star~~ **Malnutrition**

Due to..... **poor**

Other conditions (Include pregnancy within 3 months of death)

9. Birthplace **Miss.** (City, town, or county) (State or foreign country)

10. Usual occupation **Labor**

11. Industry or business

MOTHER FATHER { 12. Name **Willis Williams** 13. Birthplace **Miss.** 14. Maiden name **Rachel Brown** Birthplace **Miss** (City, town, or county) (State or foreign country)

Major findings: Of operations..... Of autopsy.....

PHYSICIAN
Underline the cause to which death should be charged statistically

16. (a) Informant's own signature **Bernice Williams** (b) Address **1418a. Franklin**

17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **11/20/40** (Month) (Day) (Year)

(c) Place: burial or cremation **Washington Park**

18. (a) Signature of funeral director **Dement & Son** (b) Address **2631 Wash St.**

19. (a) **NOV 20 1940** (Date received local registrar) (b) **J. F. Bardsley** (Licensed Embalmer's Statement on Reverse Side)

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify).....

(b) Date of occurrence.....

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at **home**? (Specify type of place) (e) Means of injury

23. Signature **E. A. McRouel** (M. D. or other) Address **2601 N Whittier** Date signed **11/18/40**

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____, Registered Apprentice No. _____ working under my personal supervision.

Signed Thomas B. Bay
Licensed Embalmer No. 1295

P. O. Address St. Louis

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.